NOVA SCOTIA

Department of Health

MENTAL HEALTH LEGISLATION

Discussion Paper

Prepared By: Mental Health Legislation Development Committee

March, 2004

http://www.gov.ns.ca/health/reports.htm

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NOVA SCOTIA
Department of Health

PO Box 488
Halifax, NS B3J 2R8

MEMORANDUM

TO: Mental Health Stakeholders

FROM: Linda Smith and Dennis Holland, Co-Chairs, Mental Health Legislation Development Committee

DATE: March 18, 2004

RE: **Mental Health Legislation Discussion Document**

Enclosed please find a copy of the Nova Scotia Department of Health Mental Health Legislation Discussion Paper for your perusal. We would appreciate receiving your feedback on this document by **Friday, April 30th, 2004**.

Please respond directly to:

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Thank you.

Linda J. Smith
Chair
Mental Health Legislation Development Committee

Dennis Holland
Chair
Mental Health Legislation Development Committee

Enclosure

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INTRODUCTION

The mental health legislative provisions in Nova Scotia are contained in the *Hospitals Act*. This Act was enacted in 1977 and came into force in 1979 and pre-dates the *Canadian Charter of Rights and Freedoms* ("*Charter*").[1]

There have been many scientific advances in the field of mental health since the development of the *Hospitals Act*. Today, nearly thirty years later, there is greater reliance on scientific evidence and a greater understanding of the prognosis and effective treatments of mental illness. These advances in treatment have been accompanied by a shift towards community-based services, resulting in a network of over fifty community mental health clinics throughout the province as well as the development of a number of mental health specialty services and community supports. Our current approach to mental health includes an appreciation of population health philosophy which encourages supporting "wellness", "independence" and "self-determination" and assists in providing the means to achieve them.

Mental health services have been integrated into the general health care system with mental health being one aspect of an individual's overall health. Today, mental health emergency/crisis services are integrated in the overall emergency room services of the nine District Health Authorities and the IWK Health Centre. As with other jurisdictions across the country, Nova Scotia has moved away from stand-alone psychiatric facilities. Today, acute psychiatric inpatient beds are integrated in the general health facilities under the District Health Authorities/IWK Health Centre. Currently, there are approximately 206 acute psychiatric beds for children, youth and adults in the province, with these beds divided among eight of the nine District Health Authorities and the IWK Health Centre. Also, consistent with national trends, the average length of stay for patients admitted to psychiatric units has decreased over the last decade. In Nova Scotia, the average length of stay is less than 24 days. These changes have significant meaning for the operation of the mental health system. New mental health legislation needs to reflect the current practices in the area of mental health treatment.

Mental health legislation of Nova Scotia has been under scrutiny for a number of years.[2] In the Fall of 2001, the provincial Department of Health identified mental health legislation as needing review. In January 2002, the Mental Health Legislation Development Committee (Committee) was struck. This Committee is a multi-disciplinary team consisting of representatives from various disciplines.[3] The Committee spent close to two years reviewing the mental health provisions of the *Hospitals Act*. In the early stages of the process, the Committee agreed that its goal was to work together to create a stand-alone mental health statute. This new legislation will be called the *"Mental Health Act"*.

This Discussion Paper is limited to a review of mental health provisions for civil committal. Although the *Criminal Code* contains provisions for dealing with persons who are accused of an offence and are found not to be responsible for the offence because of a mental disorder - the Mental Disorders Section XX.1.[4] Those provisions were not within the mandate of this review.

This Discussion Paper details those issues that the Committee reviewed and outlines its recommendations on those particular issues.[5] The Discussion Paper is divided into several parts, with each part containing several sub-sections. Following each sub-section, the reader is presented with one or more questions. Part I of this Discussion Paper reviews the topic of guiding principles. Part II explores the specific issues relating to admission, including identifying those individuals to whom the Act applies, the criteria for admission, various means of accessing admission, and time limits. Part III considers issues relating to consent to treatment, including determinations of capacity and substitute decision makers. Part IV introduces the topic of Community Treatment Orders. Part V covers issues relating to patient rights and rights advisors and Part VI deals with issues relating to the Review Board. Part VII contains miscellaneous items.

PART I: GUIDING PRINCIPLES

In its review of the mental health provisions of the *Hospitals Act* and discussion of new mental health legislation, the Committee adopted and was guided by the following principles. The principles are not presented in an hierarchical listing.

> Therefore, it is the intent that any intervention in the affairs of a patient under or in the pursuance of this Act will conform with the following guiding principles:
>
> I. Persons of all ages suffering with mental disorders are entitled to be treated with the same dignity and respect that all humans deserve;
>
> II. Each person has the right to make treatment decisions to the extent of their capacity to do so;
>
> III. Treatment and/or related services are to be offered in the least-restrictive manner and environment with the goal of having the patient continue to live in the community or return to their home surroundings at the earliest possible time;
>
> IV. Treatment and/or related services should promote the patient's self-determination and self-reliance;
>
> V. The patient has the right to a treatment plan which maximizes the person's potential and is based on the principles of evidence-based practice and best practice;
>
> VI. Persons with mental disorders should have access to mental health services as close to the person's home as practicable;
>
> VII. Ensure that any declaration of involuntary status or incapacity is made on the basis of evidence that is clear and convincing.

In selecting these principles, the Committee was guided by principles that have been adopted in various United Nations documents,[6] the *Canadian Bill of Rights*[7] and the *Charter*.[8]

It is the recommendation of the Committee that the new mental health legislation include the above identified principles.

Question 1

A. Do you agree or disagree with the guiding principles identified and adopted by the Committee?

B. Are there other principles that you would like to see included?

C. Do you agree or disagree that guiding principles should be included in mental health legislation? Explain your answer.

PART II: ADMISSION

A. Voluntary Admission

The current provisions of the *Hospitals Act*[9] do not contain any explicit provisions for voluntary admission to a psychiatric facility. The Act specifies that a person who is admitted to a psychiatric facility is admitted as "a person for observation".[10] According to the provisions in the Act, a person may be admitted for observation by (i) the consent of the patient and upon the request of a qualified medical practitioner that the patient requires the in-patient services of the facility; (ii) by medical certificates; (iii) by transfer from another facility; or (iv) by transfer from a facility in another jurisdiction.[11] According to the current provisions, when a person is examined either as a result of a court order authorizing a medical examination or apprehension by a peace officer, the person must be immediately released at the end of the examination unless the physicians examining the person admit the person for observation or unless the person voluntarily admits him or herself to a facility for observation.[12] The Act also stipulates that at the end of the observation period, if the psychiatrist does not declare that the person is an involuntary patient, the patient must be released unless the patient remains voluntarily.[13]

In practice, where it is clinically indicated that a person requires in-patient psychiatric services, the person can be admitted on a voluntary basis pursuant to clinical practice guidelines.[14] The reality is that when a person visits his or her primary care physician for a medical examination, the physician may arrange for psychiatric assessment where the physician is of the opinion that the person has a mental disorder. In such circumstances, the patient may voluntarily agree to the psychiatric assessment. The psychiatrist may recommend admission for assessment and treatment to which the patient agrees.

The Committee agreed that where a person voluntarily agrees to admission to a psychiatric facility, voluntary admission should be available where suitable. As noted by Gray *et al.*, it is preferable for a person to be admitted as a voluntary patient rather than as an involuntary patient.[15] The Committee agreed that the following clause should precede the provision detailing methods of admission.

A person may be admitted on a voluntary basis to a designated psychiatric unit following clinical assessment.

The consensus of the Committee was that the primary mode of admission to a designated psychiatric unit is to be voluntary.

B. Criteria for Involuntary Admission

Where involuntary committal is necessary, the criteria generally consists of three components: the first being the existence of a mental illness, the second being dangerousness or inability to care for oneself[16], and the third being the person requires inpatient services. The existence of a mental illness alone is not sufficient for involuntary committal, neither is dangerousness or inability to care for oneself. Some jurisdictions require the mental illness to be linked to the dangerousness or inability to care for oneself. In other words, the dangerousness or inability to care for oneself must be as a result of the mental illness. In other jurisdictions, a linkage between these two components is not necessary. For example, Nova Scotia's current provisions for admission to a psychiatric facility are the existence of a mental illness and dangerousness to oneself or others. There is no explicit requirement that there be a linkage between the two components.

The Committee prefers adoption of admission criteria that links the two components. It is the linkage between the mental illness criteria and the dangerousness or inability to care for oneself which is the basis under which some people may be treated differently by the law from all others whose actions are inconvenient or damaging or who may be simply unable to care for themselves.[17]

The following three sub-sections outline the Committee's recommendations for defining the three components necessary for both the period of observation and for involuntary admission to a psychiatric facility. Although the components are the same, the standard to be applied is different. The standard is discussed in sub-sections D(i) and D(iii).

Question 2
Do you agree or disagree with the recommendation to link the two components of the admission criteria? Why?

1) The First Component: Mental Disorder

In defining the mental illness component, the Nova Scotia *Hospitals Act* uses the term "psychiatric disorder", which is defined as "any disease or disability of the mind and includes alcoholism and drug addiction".[18]

How jurisdictions define the mental illness component is inconsistent, both nationally and internationally. In its discussions, the Committee considered the various approaches and definitions that are in use. Although some jurisdictions do not define the mental illness component, the Committee agreed not to follow such an approach since a failure to define the mental illness component can result in a decision that is unreliable or arbitrary.[19]

The Committee is in agreement that the appropriate approach for defining the mental illness component is through a list of disorders of mental function.[20] Some definitions under this approach in other jurisdictions are as follows:

> "*Mental Disorder*" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs (i) judgement, (ii) behaviour, (iii) capacity to recognize reality, or (iv) ability to meet the ordinary demands of life.[21]

> "*Mental Disorder*" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs a person's:
>
> (a) behaviour,
>
> (b) judgement,
>
> (c) capacity to recognize reality, or
>
> (d) ability to meet the ordinary demands of life,
>
> but does not include the disorder known as mental retardation.[22]

The Committee also endorses the Nova Scotia Law Reform Commission's recommendation that the term "mental disorder" be used in place of the present term of "psychiatric disorder".[23] The

Committee recommends the adoption of the definition of "mental disorder" found in the *Uniform Mental Health Act* :

> "Mental Disorder" means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life.[24]

Question 3
A. Do you agree with the use of the term "mental disorder"?
B. Do you agree with the recommended definition? If not, why not?

2) The Second Component: Harm to Self or Others/Dangerousness

Under the current criteria for involuntary admission under the *Hospitals Act*, the second component requires that 'a person pose a danger to the safety of himself/herself or to the safety of others'.[25] This criteria for the second component of involuntary admission is consistent with other Canadian mental health legislation. In some jurisdictions, the second component also allows for involuntary admission based on the criterion of "substantial mental or physical deterioration".[26]

The Committee retained the concept of dangerousness in being part of the criteria, but suggests a more tightly circumscribed definition. The Committee also recognized the value of including in the second component criteria that in limited circumstances allow for the involuntary admission of a person who is suffering from a mental disorder, and because of the mental disorder is unable to care for him/herself and as a result is likely to suffer impending serious physical impairment and/or impending serious mental deterioration. The Committee recommends that the second criteria be attributable to the mental disorder.

3) The Third Component: Requires Inpatient Services

This ensures that a person requires inpatient services and is not able to be admitted as a voluntary patient.

The Committee recommends the following three linked components as criteria for involuntary admission:

1. A person suffers from a mental disorder

And

2. a) as a result of the mental disorder, the person shows or has recently shown a lack of ability to care for himself or herself, and

b) as a result of the mental disorder, the person is likely to suffer impending serious physical impairment and/or impending serious mental deterioration,

Or

c) as a result of the mental disorder, the person i) is threatening or attempting to cause bodily harm to self or has recently done so, or has recently caused bodily harm to self, or ii) is behaving violently or is threatening violence towards another person or has recently done so, and

d) the psychiatrist is of the opinion that, as a result of the mental disorder, the person is likely to cause serious bodily harm to self or others,

And

3. The person requires inpatient services[27] and is not suitable for inpatient admission as a voluntary patient.

Question 4
Do you agree or disagree with the proposed criteria for involuntary admission to a psychiatric facility? Why?

C. Terminology

The terminology used in the *Hospitals Act* regarding the status of a patient is "informal" and "formal".[28] For the purpose of clarity in the legislation, the Committee recommends using the terms "voluntary" and "involuntary" to describe the status of the patient, rather than "informal" and "formal".

D. Involuntary Admission

Under the current provisions of the *Hospitals Act*, the process for involuntary admission includes a distinct three-phase process: (i) medical examination/certificates, (ii) period of observation and (iii) admission. The following sections describe the current process and set out the Committee's recommendations.

(i) Medical Examination/Certificates

Under the current Act, in order for a medical certificate to be completed, the person must first be examined by a physician. This can occur via several routes. A physician may take the initiative to complete an examination, a judge may order an examination, or a peace officer may detain and transport a person for a medical examination. The parameters surrounding these interventions are briefly described:

Physician Initiated

A physician may, upon carrying out a medical examination, determine that a patient requires a psychiatric assessment. In such circumstances, the physician will complete a medical certificate - discussed below.

Court Order

Any person may present evidence before a judge requesting an order for an involuntary medical examination of another person by a physician.[29] Upon hearing the evidence, a judge may issue a court order authorizing/directing a physician to visit and examine the person. Alternatively, where the person cannot be examined by the physician via a visit, the judge can issue a warrant for the person's apprehension and direct that the person be detained for medical examination.[30] However, a judge cannot order an involuntary admission.

Peace Officer

The *Hospitals Act* also sets out criteria authorizing peace officers to take a person for a medical examination. In addition to the provisions whereby a court order authorizes a peace officer to detain and take a person for a medical examination or where two certificates authorize a peace officer to take the person to a psychiatric facility, the *Hospitals Act* also authorizes intervention by peace officers in certain circumstances. The Act provides that where a peace officer has "reasonable and probable" grounds to believe that a person suffers from a mental disorder and is either a danger to his or her own safety or the safety of others, or is committing or about to commit an indictable offence, the peace officer is authorized to detain and take the person to an appropriate place for a medical examination.[31]

The medical examination may take place in a physician's office or, in many cases, the emergency department of a hospital. If, upon the completion of the medical examination, the physician determines that the person meets the prescribed criteria, the physician can issue a medical certificate. The current criteria requires that the physician has "reasonable and probable grounds" to believe that the person suffers from a mental disorder; that the person requires in-patient services, and that care cannot be provided adequately outside the facility because the person is a danger to his or her own safety or the safety of others.[32] A second certificate must also be completed by another physician.

The completion of the two medical certificates is sufficient authority to detain and transport the person to a psychiatric facility for a "period of observation",[33] which is discussed further on page 16. The *Hospitals Act* also permits one certificate to be sufficient authority where there are compelling circumstances and a second physician is not readily available to complete the second certificate.[34]

Committee's Recommendations

The Committee is not recommending substantial changes to the provisions regarding avenues of admission. The Committee recommends the continuation of provisions that allow for a peace officer to have authority to detain a person and take him or her for a medical examination, a judge to issue a warrant for the detention and medical examination of a person.[35] The Committee also recommends that physicians have authority to send a person for a psychiatric assessment by completing the medical certificates after a medical examination has been carried out. The psychiatric assessment may include an admission for a "period of observation". The Committee recommends the inclusion of more specific criteria for the exercise of the authority.

(1) For Issuing a Medical Certificate

The Committee recommends that in order to issue a medical certificate, the three components set out in the criteria must be met. The Committee recommends that for the application of the criteria to justify the issuance of a medical certificate, the current standard to be applied by a physician should be maintained. Thus, the physician would have to have "reasonable and probable grounds" to believe that the criteria are present. The recommended provisions would read as follows:

The physician has reasonable and probable cause to believe that:

1. A person suffers from a mental disorder,

And

2. a) as a result of the mental disorder, the person shows or has recently shown a lack of ability to care for himself or herself, and

b) as a result of the mental disorder, the person is likely to suffer impending serious physical impairment and/or impending serious mental deterioration,

Or

c) as a result of the mental disorder, the person i) is threatening or attempting to cause bodily harm to self or has recently done so, or has recently caused bodily harm to self, or ii) is behaving violently or is threatening violence towards another person or has recently done so, and

d) the physician is of the opinion that, as a result of the mental disorder, the person is likely to cause serious bodily harm to self or others,

And

3. *The person requires inpatient services and is not suitable for inpatient admission as a voluntary patient.*

Question 5
Do you agree with the proposed standard that is to be applied by physicians?

(2) For a Court Order

The Committee recommends that the following wording be included in new legislation:

1. Any person may make a written statement under oath or affirmation before a judge of the court[16] requesting an order for the involuntary medical examination of another person by an appropriate physician and setting out the reasons for the request, and the judge shall receive the statement.

2. A judge who receives a statement under sub-section (1) shall consider the statement and, where the judge considers it necessary to do so, hear and consider without notice the allegations of the person who made the statement and the evidence of any witnesses. The default is to hear the matter with notice.

3. The judge may issue an order for the involuntary medical examination of the other person by an appropriate physician if the judge has reasonable cause to believe that the person is suffering from a mental disorder and will not consent to undergo the examination by a physician and also that one of the following two conditions be fulfilled:

A. The person shows or has recently shown a lack of ability to care for himself or herself, and is likely to suffer impending serious physical impairment and/or serious mental deterioration.

Or

B. The person,

(i) is threatening or attempting to cause bodily harm to himself or herself or has recently done so, or has recently caused bodily harm to self; or

(ii) is behaving violently or is threatening violence towards another person, or has recently done so,

and the person is likely to cause serious bodily harm to himself or herself or to another person.

The Committee also recommends that the legislation contain the following requirements:

1. A hearing will be held on the application unless the judge deems the application to be frivolous, vexatious or malicious.
2. If a hearing proceeds, notice is to be given to both parties. (ie. the default is to give notice to the parties), but
3. Where the judge considers it necessary, the judge can proceed with the hearing *ex parte*.

It is recommended that the appropriate court is to be the Supreme Court, Family Division or Family Court.

Question 6
A. Do you agree with the inclusion of a provision allowing for a judge to issue an order for a medical examination?
B. Specifically, do you agree with the criteria for obtaining an order from a judge?

(3) For Peace Officer Intervention

The ability of a peace officer to take an individual into custody where the person is about to commit or is committing an indictable offence is in the current legislation. No other province/territory has an equivalent provision.

The Law Reform Commission recommended that the definition be broadened to include all offences. However, it was the view of the Committee that petty crimes such as vagrancy should not be swept into the definition. Rather, it recommended that the current provision pertaining to detainment when an indictable offence is involved should be maintained. The difference in

what the Committee is recommending and the current criteria is the inclusion of wording that reflects the Committee's recommendations for changes in the involuntary admission criteria.

The Committee recommends that the following wording be included in new legislation:

> *A peace officer may take a person into custody and take him or her forthwith to a place for involuntary medical examination by a physician, if the peace officer has reasonable cause to believe that the person is suffering from a mental disorder, that the person will not consent to undergo a medical examination by a physician and that it is not feasible in the circumstances to make application to a judge for an order for involuntary medical examination by a physician, and where one of the following conditions is fulfilled:*
>
> *1. The peace officer must also have reasonable cause to believe that the person shows or has recently shown a lack of ability to care for himself or herself, and the peace officer is of the opinion that the person is likely to suffer impending serious physical impairment and/or serious mental deterioration; or*
>
> *2.(i) the person is threatening or attempting to cause bodily harm to himself or herself, or has recently done so, or*
>
> *(ii) is behaving violently or is threatening violence towards another person or has recently done so, and*
>
> *the peace officer is of the opinion that the person is likely to cause serious bodily harm to himself or herself or to another person; or*
>
> *3. The peace officer has reasonable cause to believe that the person is about to commit or is committing an indictable offence.*

Question 7
A. Do you agree with the inclusion of a provision that allows for a peace officer to detain a person?
B. Do you agree with the intervention of a peace officer being limited to circumstances involving an indictable offence?

(ii) The Observation Process

The current provisions of the *Hospitals Act* refer to this stage of the admission process as a "period of observation".[37] During this period, which cannot exceed 7 days and can be as short as a few hours, there must be a medical examination and a psychiatric examination of the patient. A qualified medical practitioner must conduct the medical examination within 24 hours, and a psychiatrist must conduct the psychiatric examination within 3 days. A decision must be made as soon as practicable (not exceeding 7 days) as to whether or not the person meets the criteria for involuntary admission.[38]

If the psychiatrist determines that the patient does not meet the criteria for involuntary admission, the person must be discharged or may be admitted as a voluntary patient. If the psychiatrist determines that the patient meets the criteria, the psychiatrist must complete a declaration stating that "the patient suffers from a psychiatric disorder and is a danger to his or her own safety or the safety of others".[39] This declaration is all the authority that is necessary for a person to be detained as an involuntary patient.[40]

The Committee recommends that this period of time be continued to be referred to as "the period of observation". The benefit of referring to this as the "period of observation" is that there is a distinction clearly made between the period when a person is being assessed and when a determination is made as to whether the person requires involuntary admission.

(iii) The Admission

As noted above, under the current provisions the standard that a physician must apply when determining whether the criteria are met to issue a medical certificate is one of 'reasonable and probable grounds'. However, upon the completion of the observation period and a psychiatrist is admitting a person involuntarily, the psychiatrist must apply a higher standard, he or she must be able to state that the criteria are, in fact, met. The Committee recommends maintaining a

stricter standard to be applied when a psychiatrist is admitting a person involuntarily than when the physician is assessing whether the criteria is met for issuing a medical certificate.

The Committee recommends that the determination of whether a person should be involuntarily admitted should be made on the basis of "clear and convincing" evidence. Therefore, the psychiatrist would have to have "clear and convincing evidence" on which to base his or her decision that the criteria are met. The criteria for involuntary admission, which is set out on page 9, would read as follows:

> *The psychiatrist has clear and convincing evidence that*
>
> *1. A person suffers from a mental disorder,*
>
> *And*
>
> *2. a) as a result of the mental disorder, the person shows or has recently shown a lack of ability to care for himself or herself, and*
>
> *b) as a result of the mental disorder, the person is likely to suffer impending serious physical impairment and/or impending serious mental deterioration,*
>
> *Or*
>
> *c) as a result of the mental disorder, the person i) is threatening or attempting to cause bodily harm to self or has recently done so, or has recently caused bodily harm to self, or ii) is behaving violently or is threatening violence towards another person or has recently done so, and*
>
> *d) the psychiatrist is of the opinion that, as a result of the mental disorder, the person is likely to cause serious bodily harm to self or others,*
>
> *And*
>
> *3. The person requires inpatient services and is not suitable for inpatient admission as a voluntary patient.*

Once a person is declared an involuntary patient, he or she is admitted as such. The status of being an involuntary patient triggers an assessment of capacity. Discussion of capacity and consent to treatment is discussed in Part III. Likewise, the admission as an involuntary patient triggers certain procedural requirements relating to the Review Board. These provisions are discussed in Part VI. The duration of involuntary admissions is set out in the next section.

E. Time Limits

(1) Examinations

Currently, under the provisions of the *Hospitals Act*, when the person is apprehended by a peace officer or brought to a facility under court order, the person must be examined by a qualified medical practitioner "forthwith or as soon as practicable", with the period not to exceed 24 hours.[41] The Committee recommends that this time frame be maintained.

The current provisions also stipulate that a person, once admitted for psychiatric observation, must be examined by a qualified medical practitioner within 24 hours of admission and by a psychiatrist of that facility within 3 days of admission.[42] A decision must be made within 7 days as to whether the person will be admitted as an involuntary patient. In considering the appropriate time periods, the Committee considered the context of mental health services in both rural and urban areas. It is recognized that in rural areas, an examination by a psychiatrist may not be possible within shorter periods of time. This is reflective of psychiatric resources in rural areas. However, the Committee also recommends that the psychiatric examination be completed as soon as possible. Therefore, the Committee recommends that the "psychiatric examination be completed as quickly as possible and in no case longer than 72 hours." The Committee also recommends that the 7-day time period for determining whether a person is to be admitted as a involuntary patient be maintained.

(2) Detention Periods

According to the current provisions, an individual may be admitted as an involuntary patient for an initial period of up to one month. Renewals may occur, with the first renewal for up to a three-month period, a second renewal for up to three months, and any subsequent renewals for up to six months.[43] There is currently no limit on the number of renewals. In discussing renewal periods, the Law Reform Commission suggested that the duration of renewal periods should "reflect a balance between the need to properly evaluate a patient and the need to limit

restrictions on a patient's personal freedom."[44]

The Committee recommends the adoption of the provisions in the *Uniform Mental Health Act*.[45] The detention period on the original certificate will be maintained at a maximum of one month, with a renewal requiring a renewal certificate. The first renewal will extend the detention period up to an additional one month. If required, a second renewal certificate will extend the detention up to an additional 2 months, and a third renewal certificate will extend the detention period for up to an additional 3 months. If detention is required beyond the third renewal, a renewal certificate will be required every 3 months thereafter.

Table 1: Proposed Duration of Involuntary Certificates

	Initial Certificate	**1st Renewal**	**2nd Renewal**	**3rd Renewal**	**Subsequent Renewals**
Duration	1 month	1 month	2 months	3 months	3 months
Total Running Time	1 month	2 months	4 months	7 months	10, 13, 16, etc.

PART III: CONSENT TO TREATMENT

The common law rule is that medical intervention may only be provided when the consent of the individual to be treated has been obtained. The Supreme Court of Canada has confirmed this fundamental right of an individual to make treatment decisions.[46] Thus, when a patient has capacity to make treatment decisions, he or she can give or refuse to give consent to treatment. The caveat to this common law rule is that in order to make a treatment decision, the person must have capacity to do so. The question of capacity surfaces most often in the cases of minor children and adults with mental disorders.[47]

There are four basic requirements for a consent to treatment to be legally valid: consent must be voluntary; must be given by a person who has capacity to consent; must refer to both the treatment and the provider; and must be informed.[48]

The current provisions of the *Hospitals Act* do not set out the requirements for a valid consent. Although the Committee is not recommending that all four elements be stipulated in the new legislation, it is recommending that a clause be included stating that "consent must be informed." The following sections outline the Committee's recommendations for (a) criteria for determining capacity; (b) the approach to consent to treatment; and (c) criteria for substitute decision making. It is intended that this part is not only for patients receiving mental health sessions but applies to all patients receiving health services in hospitals.

A. Determining Capacity

Before looking at the factors that must be considered in a capacity assessment, it should be noted that the starting point is a presumption of capacity. The Committee is of the opinion that the presumption of capacity should be explicitly stated as the starting point for capacity assessments. That is, a person is presumed to be capable of consenting to treatment until there is a determination made that the person is incapable of consenting to treatment.

(1) Competing Values in Setting a Test for Capacity

There are competing fundamental values inherent in the determination of capacity, values which legislation must aim to balance. In a recent Supreme Court of Canada decision,[49] Chief Justice McLachlin discussed the competing fundamental values in determining how to assess capacity. She identifies them as:

> (1) autonomy: the ability of each person to control his or her body and consequently, to decide what medical treatment he or she will receive, and
>
> (2) effective medical treatment: that people who are ill should receive treatment and that illness itself should not deprive an individual of the ability to live a full and complete life.[50]

The Chief Justice stated that "ordinarily at law, the value of autonomy prevails over the value of effective medical treatment. No matter how ill a person, no matter how likely deterioration or death, it is for that person and that person alone to decide whether to accept a proposed medical treatment."[51] Furthermore, health care providers, when determining capacity, cannot be guided by what they feel is in the "best interest" of the patient. They must focus on whether the patient has the capacity to make the decision.[52]

(2) Other Factors to Consider When Setting the Test for Capacity

It is suggested that there are five themes that should underlie each capacity assessment.[53] These themes are:

1. Legal incompetence [incapacity] is related to, but not the same as, impaired mental state.[54]

Physicians must be careful not to presume someone to be incapable to make a decision simply because they have a mental disorder. "The presence of mental illness, mental retardation, or dementia alone does not render a person incompetent."[55] According to the Supreme Court of Canada, "unwarranted findings of incapacity severely infringe upon a person's right to self-determination."[56] The presumption of capacity must remain present when evaluating psychiatric patients, but historically there has been a failure to recognize this presumption.[57] The Supreme

Court of Canada specifically recognizes that a presumption of capacity is not lost by the mere fact of an involuntary admission:

> The Board must avoid the error of equating the presence of a mental disorder with incapacity. Here, the respondent did not forfeit his right of self-determination upon admission to the psychiatric facility....The presumption of capacity can be displaced only by evidence that a patient lacks the requisite elements of capacity provided by the Act.[58]

In the *Starson* case, Chief Justice McLachlin stated that in the Ontario legislative scheme, mental illness is not conflated with incapacity:

> ...mental illness without more does not remove capacity and autonomy. Only where it can be shown that a person is unable to understand relevant factors and appreciate the reasonably foreseeable consequences of a decision or lack of decision can treatment be imposed.

Under the existing *Hospitals Act*, mental illness is not conflated with incapacity. This separation of mental illness and capacity is in accordance with the approach endorsed by the Supreme Court of Canada.

2. Legal incompetence [incapacity] refers to functional deficits.[59]

Physicians (and other health care professionals) should consider the following abilities, among others, when assessing a patient's capacity: orientation, attention, memory, intelligence, abstract thinking and problem-solving.

3. *Legal incompetence [incapacity] depends on functional demands.*[60]

Depending on the type of decision to be made, a different level of capacity may be required. The test for capacity is functional - the focus of the inquiry is whether the patient has the ability to understand the nature and effect of the treatment being proposed, not the "global" capacity of the individual."[61] In law, at present, there is an understanding of "specific competencies", where different levels of capacity are required for different domains, as opposed to the old view that competency was an "all or nothing" judgement.[62] The necessary capacity level will vary with the

medical and social context of the decision, individual clinical circumstances, and the risks and benefits of the treatment.[63]

4. Legal incompetence [incapacity] depends on consequences.[64]

A lower level of capacity will be required for a high-benefit, low-risk treatment, where a higher level will be required for a low-benefit, high-risk treatment. A patient may, for example, be able to understand the nature of a blood test, but not that of heart surgery.[65] The consequences of a treatment decision will be different for different people, depending on their medical, psychological and social characteristics.[66]

5. Legal incompetence [incapacity] can change.[67]

"People's cognitive and emotional states may change or fluctuate, influencing changes in critical decision-making abilities."[68] Therefore, capacity decisions are treatment specific and one's capacity may indeed change from treatment to treatment.

(3) Criteria for Determining Capacity

Nova Scotia's existing *Hospitals Act* sets out the factors that a psychiatrist must consider when determining a patient's capacity to consent to treatment. These factors apply to all patients, including psychiatric patients. When conducting a capacity assessment, the psychiatrist is required to consider whether or not the person being examined:

(a) understands the condition for which the treatment is proposed;
(b) understands the nature and purpose of the treatment;
(c) understands the risks involved in undergoing the treatment;
(d) understands the risks involved in not undergoing the treatment; and
(e) whether or not his ability to consent is affected by his condition.[69]

Ontario's *Capacity and Consent to Treatment Act* also sets out factors for determining capacity, which are similar to those found in the Nova Scotia *Hospitals Act.* Provinces approach the

determination of capacity in different ways. In Ontario, for example, the *Health Care Consent Act* at s. 4(1) defines capacity as follows:

> A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.[70]

This definition of capacity breaks the assessment into two steps - ability to understand the relevant information and ability to appreciate the reasonably foreseeable consequences of making the decision. The person must pass both steps in order to be found capable to consent to treatment. Other Canadian jurisdictions use variations of the Ontario or Nova Scotia test for determining capacity.

The Law Reform Commission recommended that current criteria for determining capacity be maintained. The Committee recommends the adoption of a provision similar to that contained in the Manitoba mental health legislation:

> *In determining a patient's mental capacity to make a treatment decision, the appropriate physician shall consider*
>
> *(a) whether the patient is able to understand*
>
> *(i) the condition for which the specific treatment is proposed,*
>
> *(ii) the nature and purpose of the specific treatment,*
>
> *(iii) the risks and benefits involved in undergoing the specific treatment, and*
>
> *(iv) the risks and benefits involved in not undergoing the specific treatment; and*
>
> *(b) whether the patient's mental disorder affects his or her ability to appreciate the consequences of making this treatment decision.*

The Committee does not recommend the inclusion of provisions regarding the determination of capacity for individuals under the age of majority.

The Committee also discussed "who" should be able to conduct a capacity assessment. The Committee recommends that the capacity assessment should be completed by a psychiatrist when the assessment is conducted during the involuntary admission process. Furthermore, the Committee supports the recommendation of the Law Reform Commission that other specially qualified health care professionals should be permitted to complete capacity assessments in situations outside the involuntary admission process.

Question 8
A. Do you agree with the recommendation to include a clause stating "consent must be informed"? Why?
B. Do you agree with the recommendation to include a clause explicitly stating that the presumption is one of capacity?
C. Do you agree with the recommended criteria for determining capacity? Why?
D. Do you agree with the recommendation of allowing capacity assessment to be conducted by other qualified health care professionals in limited circumstances?

B. Approach to Consent to Treatment

In the context of mental health, jurisdictions vary on how they have addressed the issue of consent to treatment with respect to involuntary admission. The following discussion briefly looks at the approaches the Committee reviewed and presents two models for consideration.

1. Nova Scotia Approach

The current approach in Nova Scotia regarding consent to treatment does not distinguish between mental health patients and other patients, nor does it distinguish between voluntary and involuntary patients. The *Hospitals Act*, which governs all patients in hospitals, including psychiatric facilities, stipulates that treatments cannot occur unless the patient has consented to the treatment, or where the person is declared to be incapable of consenting, consent is obtained from a substitute decision maker.[71] However, the provisions dealing with *when* a capacity assessment takes place differ for patients admitted to a psychiatric facility and patients admitted to hospital.

The provisions of the *Hospitals Act* mandate that a psychiatrist conduct an examination to determine if a patient is capable of consenting to treatment (capacity assessment) at least once every 3 months during the first year that a person is a patient and at least once every twelve months thereafter. The psychiatrist can also do a capacity assessment as the need arises.[72] Until a declaration of incapacity is made, the presumption is that the patient has capacity.[73] These provisions apply to all hospitals including a psychiatric facility. The *Hospitals Act* also contains provisions specifically for psychiatric facilities. It requires that every patient who is admitted to a psychiatric facility must be examined by a psychiatrist for the purpose of determining capacity within three days of admission to the facility.[74]

Although the timing of when a capacity assessment occurs differs, the end result of the determination does not change. If there is a finding of capacity, the patient has the right to make his or her own treatment decisions. If there is a finding of incapacity, consent must be obtained from a substitute decision maker.

The result of this approach is that a person who meets the criteria for involuntary admission to a psychiatric facility and upon examination is found capable of making treatment decisions may refuse to consent to treatment. Therefore, a capable person may be held under involuntary status under the provisions of the *Hospitals Act* but not receive treatment. Critics of this approach argue that the purpose of mental health legislation is to provide treatment to those with a mental disorder and that a legislative scheme that results in the state being able to involuntarily detain a person but not to treat that person is deeply problematic.

The argument presented in favour of such an approach is that the right of a person who has capacity to make his or her own treatment decisions is a fundamental right that cannot be interfered with. Proponents point to decisions of the higher courts in Canada, including those of the Supreme Court of Canada, that have upheld the right of a person who has capacity to accept or refuse treatment even when a refusal of treatment may result in death to the person.

2. British Columbia Approach

British Columbia has taken a different approach to consent to treatment under its mental health legislation. British Columbia has a *Health Care (Consent) and Care Facility (Admission) Act*, [75] and a *Mental Health Act*.[76] Under the *Health Care (Consent) and Care Facility (Admission) Act*, there is a presumption of capacity. Every person is presumed to be capable of giving, refusing, or revoking consent to health care, until the contrary is demonstrated. However, this explicit presumption of capacity and recognition of a competent person's right to make treatment decisions does not apply to a person who is admitted to a psychiatric facility under the *Mental Health Act*.[77] Under the *Mental Health Act*, once a person is detained in a psychiatric facility, treatment authorized by the director of the facility is "deemed to be given with the consent of the patient".[78] This approach makes no distinction between involuntary admission and involuntary treatment. A determination of involuntary status gives the psychiatric facility and physicians the right to administer treatment without the patient's consent. A British Columbia court is presently reviewing this provision to determine whether it is in violation of the equality rights of the *Charter*.

Similar to British Columbia's approach, Newfoundland's *Mental Health Act* allows for treatment of an involuntary patient without consent being obtained. However, unlike British Columbia's legislation, Newfoundland's legislation makes no reference to a patient's capacity and contains no "deeming to consent" provision. Essentially, the legislation is silent on the issue of consent to treatment. It simply states that once a certificate is confirmed, the certificate is sufficient authority for the person to be detained and treated.

3. Saskatchewan Approach

Saskatchewan's mental health legislation, the *Mental Health Services Act*, does not separate involuntary admission from consent to treatment - the determination of capacity is included in the assessment. The criteria for involuntary admission include:

> (i) the person is suffering from a mental disorder, the result of which the person needs treatment or care and supervision which can only be provided in an in-patient facility;
>
> (ii) as a result of the mental disorder, the person is unable to fully understand and to make an informed decision regarding his need for treatment or care and supervision; and
>
> (iii) as a result of the mental disorder, the person is likely to cause harm to himself or to others or is likely to suffer substantial mental or physical deterioration if not detained in an in-patient facility.[79] [emphasis added]

Under this approach, if a person has a mental illness which requires in-patient services, and is a danger to self or others or the person's mental or physical condition is likely to deteriorate, but the person is able to fully understand and is able to make an informed decision regarding the need for treatment or care and supervision, the physician cannot issue a medical certificate for the involuntary admission of the person.

Where the person does meet the criteria and is admitted as an involuntary patient, unlike the Ontario model, where consent must be obtained from the substitute decision maker, under the Saskatchewan legislation, no consent is obtained and the patient may be subjected to compulsory treatment.

4. Other Jurisdictions

Ontario's approach is similar to that of Nova Scotia. The issue of involuntary admission is kept separate from the issue of capacity to consent to treatment. Under the *Health Care Consent Act*, an involuntary patient who has capacity has the right to refuse treatment.[80] Where the involuntary patient does not have capacity, consent for treatment is obtained from a substitute decision maker.[81] While the review board, the Consent and Capacity Board, can review decisions relating to the finding of capacity or incapacity, it does not have the authority to override the refusal of a person who has capacity nor the authority to make treatment decisions for patients who have capacity. Where a patient is found to be incapable, consent must be obtained from the substitute decision maker.

Manitoba's *Mental Health Act* also keeps the issue of involuntary admission separate from that of treatment. A patient of a psychiatric facility who has been found to have capacity has the right to refuse psychiatric or other medical treatment. However, there are some exceptions. One is an emergency exception, in that, where immediate treatment is necessary, treatment may be given without the patient's consent. The other exception is where a review board has authorized treatment against the express desire of the patient. Likewise, Alberta's *Mental Health Act* distinguishes between involuntary admission and treatment. An involuntary patient who has capacity has the right to refuse or consent to treatment. Where the involuntary patient is incapable to make treatment decisions, such decisions are made by the substitute decision maker. However, similar to Manitoba's legislation, Alberta's legislation allows a review panel to overturn a patient who has capacity or a substitute decision maker's decision, where the review panel is satisfied that the proposed treatment is in the best interest of the involuntary patient.[82] New Brunswick's *Mental Health Act* allows for a tribunal to order routine clinical medical treatment to be given without the patient's consent for both capable and incapable patients. The difference between Manitoba, Alberta and New Brunswick's legislation and British Columbia's legislation, is that those three provinces require a review process for the override of a capable person's refusal, whereas British Columbia does not. However, it is anticipated that provisions that allow for the override of a decision by a person who has capacity will be found to violate the provisions of the *Charter*. Cases such as *Fleming v. Reid* have illustrated that where a patient who has capacity has refused treatment the imposing of the refused treatment when the patient is incapable violates the *Charter*.[83]

As the above summary of the various approaches illustrates, Canadian jurisdictions are not uniform in their approach to the issue of consent to treatment in mental health legislation. After considering the various approaches, the Committee selected two approaches which it felt are most likely to comply with the *Charter*. The two approaches are set out below for your consideration.

5: Option A

This option is to maintain the status quo of the current provisions in the *Hospitals Act* regarding consent to treatment. The involuntary admission criteria would be as set out in Part II of the Discussion Paper. The current distinction between involuntary admission criteria and capacity would be maintained. Once a person is involuntarily admitted, a capacity assessment is conducted. Where a capacity assessment determines that the patient has the capacity to make a treatment decision, the patient would have the right to give or refuse to give consent to treatment. Where a patient is found to be incapable, consent would have to be obtained from a substitute decision maker for treatment to occur. The starting point for any assessment would be a presumption of capacity. This criteria would allow for an involuntary, yet capable patient, to refuse treatment while being detained at the psychiatric facility.

6: Option B

This option is based on the Saskatchewan model. Under this option, capacity to consent to treatment would be incorporated into the involuntary admission criteria. A capacity assessment would be done by a psychiatrist once involuntary admission is indicated. For involuntary admission to occur, the admission criteria in Part II of the Discussion Paper would need to be satisfied. In addition, the criteria could include the requirement that the person would need to be found incapable of consenting to treatment. Where the psychiatrist makes a determination that the person has capacity, the person could not be admitted as an involuntary patient. However, if the psychiatrist determines that the person does not have capacity to make treatment decisions, the person would be admitted as an involuntary patient. Once the person is admitted as an involuntary patient, consent for treatment would be sought from the substitute decision maker.

Question 9
Do you prefer Option A or Option B? Explain your answer.

C. Substitute Decision Makers

(1) Criteria for Choosing a Substitute Decision Maker

In order for treatment to occur, health care professionals must have consent, either from the patient or, if the patient is incapable, from a substitute decision maker. The current provisions of the *Hospitals Act* set out a hierarchy for substitute decision making in circumstances where the individual does not have capacity to make health care decisions. Sub-section 54(2) of the *Hospitals Act* provides as follows:

> If a person in a hospital is found by declaration of capacity to be incapable of consenting to treatment then that person may be treated either upon obtaining the consent of the guardian of that person,[84] if he has one, or if he has not a guardian upon obtaining the consent of his spouse or common-law partner, if the spouse or common-law partner is cohabiting with the person in a conjugal relationship, or next of kin, and where the spouse or common-law partner or next of kin is not available or consent is unable to be obtained upon obtaining the consent of the Public Trustee.

In order to clarify who is to be considered the "next of kin" as it is not defined in the Act, the Committee recommends the following hierarchy, which is adopted with modifications from the *Uniform Mental Health Act*, for substitute decision makers.

(1) Consent may be given or refused on behalf of a patient who does not have capacity by a person who

- *(a) apparently has capacity; and*
- *(b) is willing to make the decision to give or refuse consent; and*
- *(c) is in one of the following categories:*
  - *(i) the patient's guardian,*
  - *(ii) the spouse or common-law partner, if the spouse or common-law partner is cohabiting with the person in a conjugal relationship,*
  - *(iii) an adult child of the patient,*
  - *(iv) a parent of the patient or a person who stands in loco parentis,*[85]
  - *(v) a brother or sister of the patient,*
  - *(vi) any other next of kin of the patient, or*
  - *(vii) the Public Trustee.*

(2) *If a person in a category in sub-section (1) refuses consent on the patient's behalf, the consent of a person in a subsequent category is not valid.*

(3) *A person referred to in clauses (1)(ii) to (vi) shall not exercise the authority given by that subsection unless the person,*

- (a) *has been in personal contact with the patient over the preceding 12-month period;*
- (b) *is willing to assume the responsibility for consenting or refusing consent for a specific treatment;*
- (c) *knows of no conflict or objection from any other person in the list set out in sub-section (1) of equal or higher category who claims the right to make the decision; and*
- (d) *makes a statement in writing certifying the person's relationship to the patient and the facts and beliefs set out in clauses (a) to (c).*

Where two people, in a different rank (e.g., a parent of a patient and a sibling of a patient), are each claiming to be the substitute decision maker, the person with the highest rank shall be considered the substitute decision maker. Any dispute between two members of the same "rank" is to be resolved by the institution.

Question 10
Do you agree with the criteria that is proposed for establishing when a person can become a substitute decision maker?

(2) Criteria for Decision Making by Substitute Decision Makers

There are several approaches taken in relation to the criteria by which substitute decision makers are to make their decisions. In the *Medical Consent Act* of Nova Scotia, which allows for a person who has capacity to appoint a substitute decision maker, the Act is silent as to the criteria on which substitute decision makers are to base their decisions. Some legislation directs the substitute decision maker to make treatment decisions based on the patient's prior expressed wishes. Other legislation directs the substitute decision maker to make treatment decisions

based on what the decision maker believes is in the best interest of the patient; the substitute decision maker does not have to follow the patient's prior expressed wishes.

A third approach directs the substitute decision maker to base treatment decisions on the patient's prior expressed wishes, but where the wishes are not known, the decision should be based on what the substitute decision maker believes to be in the patient's best interest. In some legislation, there is also the ability for the substitute decision maker or the Review Board to override the patient's expressed wishes where the decision maker believes that it is in the patient's best interest to do so. However, in the decision of *Fleming v. Reid*, the court was quite clear that to impose treatment that was refused by a patient when he or she had capacity once the patient was incapable was in violation of the Charter.[86]

The Committee recommends the adoption of the following criteria:

> *The decision-maker must make a decision*
>
> *(a) in accordance with the patient's prior competent informed choice; or*
>
> *(b) in the absence of awareness of a prior competent informed choice, in accordance with what the person believes to be the person's best interests.*

Question 11
Do you agree with the adoption of these criteria?

(3) Criteria for Determining "Best Interests"

The Committee recommends adoption of Manitoba's provision regarding how "best interests"are to be determined. The provision reads as follows:

> In determining the patient's best interests regarding treatment, a person (substitute decision maker) shall have regard to all the relevant circumstances, including the following:
>
> (a) whether the patient's condition will be or is likely to be improved by the treatment;

(b) whether the patient's condition will deteriorate or is likely to deteriorate without the treatment;

(c) whether the anticipated benefit from the treatment outweighs the risk of harm to the patient; and

(d) whether the treatment is the least restrictive and least intrusive treatment that meets the criteria set out in clauses (a), (b) and (c).

Question 12
Do you agree with the proposed criteria for determining "best interests"?

PART IV: COMMUNITY TREATMENT ORDERS

Community Treatment Orders (CTOs) are, simply stated, legislative provisions that allow for an order which provides for a person with a mental disorder to receive treatment in the community. In the area of mental health policy, CTOs are receiving a great deal of attention. In its 2002 Report, the Law Reform Commission of Nova Scotia recommended the use of CTOs.

The recommendation by the Law Reform Commission on the use of CTOs follows a trend that is seen both nationally and internationally. CTOs, in various forms, have been legislated in numerous jurisdictions, including New Zealand, Israel, Scotland, England, Wales, Australia and the United States. During the past decade, Canada has seen the implementation of CTOs in two provinces, Saskatchewan in 1996 and Ontario in 2000.[87] The province of New Brunswick considered the desirability of implementing CTOs, but the Department of Health, after conducting a public consultation on the implementation of CTOs, decided against it. Although most Canadian jurisdictions do not have provisions for CTOs, many do have provisions in their mental health legislation that provide for an involuntary patient to leave the psychiatric facility.[88] The provisions can be used to facilitate discharge from the psychiatric facility and promote living in the community. These provisions are commonly referred to as "leave certificates". Leave certificates contain conditions which the patient must comply with; failure to comply can result in a forcible return to the psychiatric institution. Nova Scotia's *Hospitals Act* does not have provisions for either CTOs or leave certificates.

The discourse surrounding CTOs revolves around issues of economics, efficacy and autonomy.[89] Most discussions of autonomy vis-a-vis CTOs focus on individual rights versus state intervention.[90] Those in favour of CTOs argue that CTOs are the less restrictive alternative to an involuntary committal to a psychiatric facility because they allow the person to live in the community, and therefore offer respect for a person's autonomy. Those who argue against the implementation of CTOs take the position that CTOs are coercive and do not respect a person's autonomy. It is argued that CTOs force people to agree to treatment in the community in order

to avoid involuntary admission and also that a person may be subject to a CTO for a longer period of time than he or she would be hospitalized.[91]

In determining whether CTOs should be included in mental health legislation, the Committee was mindful of its principles, namely that persons with mental disorders should have access to mental health services as close to the person's home as practicable; treatment and/or related services are to be offered in the least-restrictive manner and environment with the goal of having the patient continue to live in the community or return to their home surroundings at the earliest possible time; treatment should promote the patient's self-determination and self-reliance; and the patient has the right to a treatment plan which maximizes the person's potential and is based on the principles of evidence-based practice and best practice. The Committee, therefore, recommends that provisions for the use of Community Treatment Orders be included in mental health legislation.

Question 13
Do you agree with the recommendation to include provisions that allow for the use of CTOs? Why?

A. Criteria

The Committee agreed that for an order to apply to a person, the following criteria had to be met:

1. There is significant evidence on the basis of previous history to believe the individual will benefit from a CTO, and
2. The person lacks capacity, and
3. The resources are available and will be provided in the community.

Specifically, the Committee makes the following recommendations for Community Treatment Order provisions:

1. *The psychiatrist has clear and convincing evidence*[92]

(i) that a person suffers from a mental disorder, and

(ii) as a result of the mental disorder, the person shows or has recently shown a lack of ability to care for himself or herself, and

(iii) as a result of the mental disorder, the person is likely to suffer impending serious physical impairment and/or impending serious mental deterioration.

***2**. There is significant evidence on the basis of past history to believe, on reasonable and probable grounds, that this person will receive benefit from being subject to a Community Treatment Order.*

***3**. The person lacks capacity.*

***4**. Where a person is or has been under a Community Treatment Order and has regained capacity but wishes to continue under the terms of a Community Treatment Order, she or he may consent to a Community Treatment Order.*

***5**. Resources as described in the Community Treatment Order*

(i) would have to exist in the community, and

(ii) are available to the person, and

(iii) will be provided to the person.

Question 14
A. Do you agree with the proposed criteria for implementing a CTO? Why?
B. Specifically, do you agree with the recommendation that a person must be incapable to be placed on a CTO? Why?

Although the criteria for a community treatment order specifies that a person must lack capacity, the Committee recognizes that capacity or non-capacity is not a constant factor. An individual who lacks capacity may regain capacity at any point in time. Thus, the Committee recommends the inclusion of a provision that will allow for a person who regains capacity to consent to remain on the community treatment order if the person so desires. Likewise, where an individual who lacked capacity at the time of the issuance of the community treatment order but

at the time of the renewal has regained capacity, the Committee recommends that the individual be allowed to consent to the renewal.

The Committee makes the following recommendation:

> *Where a person is or has been under a Community Treatment Order and has regained capacity but wishes to continue under the terms of a Community Treatment Order, she or he may consent to a Community Treatment Order.*

Question 15
Do you agree with the recommendation that a person who has regained capacity can consent to continuing on a CTO? Why?

It is the recommendation of the Committee that prior to being placed on a CTO, the individual shall be assessed by a multi-disciplinary team which will include a psychiatrist. The Committee recommends that when issuing a CTO, the order should contain at a minimum the date of the psychiatric examination and the facts on which the psychiatrist based his or her opinion.

It is also recommended that an individual being placed on a Community Treatment Order will have a care plan developed. A care plan outlines the treatment specifics for the individual. The Ontario provisions provide an illustration of the type of information that can be contained in a treatment plan:

> 1. A plan of treatment for the person subject to the community treatment order.
> 2. Any conditions relating to the treatment or care and supervision of the person.
> 3. The obligations of the person subject to the community treatment order.
> 4. The obligations of the substitute decision-maker, if any.
> 5. The name of the physician, if any, who has agreed to accept responsibility for the general supervision and management of the community treatment order....[93]
> 6. The names of all persons or organizations who have agreed to provide treatment or care and supervision under the community treatment plan and their obligations under the plan.[94]

In Saskatchewan, the provisions are not so detailed as to what must be contained in a community treatment order. The provisions merely state that a community treatment order must "describe the services that will be provided to the person and the treatment that is recommended for the person"; "state the person is to submit to medical treatment that is prescribed...and to attend appointments as scheduled..."; and "identify the names of the persons authorized by the regional director who will ensure that the person who is subject to a community treatment order will receive the services...".[95]

The Committee recommends that the specific requirements for treatment plans be set out in regulations, and that as a starting point, the requirements be similar to those contained in Ontario.

The Committee also considered notification of the issuance of a CTO. The Committee recommends that the regulations set out who the psychiatrist should inform that a CTO is being issued. The Committee recommends that notice be given to the following individuals:

- *The person or the person's substitute decision maker, along with a notice of a right to a hearing before the Review Board.*
- *The CEO of the District Health Authority/IWK*
- *The Minister of Health*
- *Any other health care practitioner or other person named in the community treatment plan.*

Question 16
Do you agree with providing notice to the identified individuals of the issuance of a CTO? Why?

B. Length of Community Treatment Order

In determining what duration should be stipulated for a community treatment order, the Committee was observant of guiding principle three, that treatment and/or related services are to be offered in the least-restrictive manner and environment with the goal of having the patient continue to live in the community or return to their home surroundings at the earliest possible time. The Committee considered the duration of community treatment orders in other jurisdictions, noting that in Ontario community treatment orders are of six months' duration, with renewals for periods of six months permitted. The Committee also considered the length of leave certificates that are used by some Canadian jurisdictions. For example, in Manitoba a leave certificate is for six months, with the ability for additional extension which cannot exceed six months.[96]

The Committee recommends the use of six-month terms, with the initial order for six months and renewals for up to six months. The following provisions are recommended:

Duration

A Community Treatment Order expires six months after the day it is made unless, (a) it is renewed or (b) it is terminated earlier.

Renewals

A Community Treatment Order may be renewed for a period of six months at any time before its expiry and within one month after its expiry. There is no limit on the number of renewals permitted.

Question 17
Do you agree with the proposed time frames for the duration and renewal of CTOs?

C. Termination of Community Treatment Order

As noted above, community treatment orders have a duration of six months. However, a community treatment order can be terminated prior to the expiry date. Both Ontario and Saskatchewan allow for early termination of a community treatment order.

The Committee recommends termination of a community treatment order at the request of the substitute decision maker to the Review Board for termination, when there is a failure by the person to comply with the provisions of the community treatment order, when the substitute decision maker withdraws his or her consent to the community treatment order, or where capacity has been regained. The Committee recommends the following provisions:

1. Early termination of order pursuant to request

(1) At the request of a person who is subject to a Community Treatment Order or of his or her substitute decision-maker, the physician (psychiatrist) who issued or renewed the order shall review the person's condition to determine if the person is able to continue to live in the community without being subject to the order.

(2) If the physician (psychiatrist) determines, upon reviewing the person's condition, that the circumstances for issuing the order no longer exist, the physician (psychiatrist) shall,

(a) terminate the Community Treatment Order;

(b) notify the person that he or she may live in the community without being subject to the Community Treatment Order; and

(c) notify any of the persons that were identified in the order that the Community Treatment Order has been terminated.[97]

2. Early termination of order on withdrawal of consent

A substitute decision-maker may withdraw his or her consent to the Community Treatment plan by giving the physician (psychiatrist) who issued or renewed the order a notice of intention to withdraw consent.

3. Early termination for failure to comply

If a physician (psychiatrist) who issued or renewed a Community Treatment Order has reasonable cause to believe that the person subject to the order has failed to comply with his or her obligations under the Community Treatment Order, the physician (psychiatrist) may issue an order for examination of the person in the prescribed form.[98]

4. Notification of termination

Where the physician (psychiatrist) terminates the Community Treatment Order, the physician (psychiatrist) must notify the Review Board and the patient/substitute decision maker of the termination.

D. Miscellaneous

(1). Information to be Provided

In keeping with the guiding principles, specifically principles 1, 4, and 7, the Committee makes the following recommendation:

> There is an obligation to provide an explanation to the individual of what is being planned for a Community Treatment Order regardless of his or her capacity to understand.

(2). Reassessment

The Committee recommends that a review of Community Treatment Order provisions in legislation be completed within five years of proclamation and a report be prepared that must be made public. The requirement for a review is consistent with the approach that was adopted in Ontario when the province introduced provisions for CTOs.

PART V: PATIENT RIGHTS AND RIGHTS ADVICE

A. Patient Rights

Under the current *Hospitals Act*, patients are granted certain rights. Some of these rights relate to the review process. They include: the right to have a file reviewed by the Review Board upon a request by the patient, or a person authorized by the patient to act on the patient's behalf;[99] the right to notice of hearing;[100] and the right to be heard at a hearing.[101] The patient also has certain rights related to communication, including: the right to not have outgoing mail withheld or examined by anyone, the right to not have incoming mail withheld or examined by anyone except the administrator who may be present at the opening of mail and may remove contents that the administrator determines are detrimental to the patient or others, the right to letter writing materials, the right to make and receive unmonitored phone calls except where the psychiatrist determines that it would be detrimental to the person or others, and the right to visitors.[102] The patient also has a right to advice and assistance regarding any of the above rights.[103] The *Hospitals Act* also stipulates that these rights are to be posted as well as distributed to patients.[104]

The inclusion of rights in mental health legislation is common in other Canadian jurisdictions. Rights pertaining to patient status include: the right to be informed of location;[105] status and reasons for being detained;[106] the right to have an interpreter if unable to understand information;[107] the right to be released against medical advice unless the patient is an involuntary patient;[108] the right to retain legal counsel; and the right to be informed of legal aid.[109]

Rights pertaining to a review board include: the right to be informed of the right to apply to the review board for review of status;[110] the right to receive notice of the appeals process; the right to appeal admission certificates or renewal certificates; the right to file an application for review on decisions pertaining to one's status as a patient;[111] and the right to apply for removal of a substitute decision maker or the reversal of a decision by the substitute decision maker.[112]

Canadian jurisdictions also include patient rights with respect to treatment. Such rights include: the right to reject treatment;[113] the right to withdraw consent;[114] the right to consent to treatment - subject to certain provisions;[115] the right to give informed consent;[116] the right to give a consent that is voluntary and not obtained through fraud;[117] the right to an independent medical opinion regarding mental disorder or treatment;[118] the right to express wishes about treatment; the right to admission to facility or personal assistance services;[119] and the right not to be subjected to abuse.[120]

The Committee recommends that the existing rights that are granted to patients under the *Hospitals Act* be maintained. The Committee also recommends the inclusion of rights respecting standards of care: the patient has the right to be protected from harm and abuse; the right to equal access to mental health services based on clinical assessment of need; and the right to the least restrictive and least intrusive measures that their condition and circumstances warrant.

The following is a summary of the Committee's recommendations pertaining to patient rights:

1. STATUS

i. right to be informed of location, status, and reasons

ii. right to have an interpreter

iii. right to be released against medical advice unless the person is an involuntary patient

iv. right to obtain legal counsel and right to be informed of legal aid services

2. TREATMENT

i. right of capable patient to reject treatment

ii. right of capable patient to withdraw consent

iii. right of capable patient to consent to treatment

iv. right of capable patient to give informed consent

v. consent must be informed, voluntary, not obtained through fraud

vi. right to independent medical opinion regarding mental disorder or treatment

vii right to express wishes about treatment, admission to facility or personal assistance services

3. STANDARDS OF CARE

i. the right to be protected from harm and abuse by other patients, staff or others

ii. the right to equal access to mental health services based on clinical assessment of need

iii. the right to least restrictive and least intrusive measures that his or her condition and circumstances warrant

4. COMMUNICATION

i. right to not have outgoing mail opened, examined or withheld, or its delivery obstructed or delayed

ii. right to not have incoming mail opened, examined or withheld, or its delivery obstructed or delayed, unless the psychiatrist is of the opinion that the mail would be detrimental to the patient. In addition, an administrator may be present at the opening of mail by the patient and may remove contents of the mail that are detrimental to the patient or others, but the correspondence cannot be withheld.

iii. right to letter writing materials

iv. right to make and receive unmonitored phone calls except where the psychiatrist on reasonable grounds determines such calls to be harmful

v. right to visitors

5. HOSPITAL RECORDS

i. right to access records, unless there is significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient or harm to a third party, with the onus resting on the physician to justify a denial of access

ii. right to obtain copies of records at the expense of the patient

iii. right to request correction to records

iv. right to require statement of disagreement to be attached to documents

v. right to confidentiality of records

vi. right to refuse release of records

6. GENERAL

i. right to be informed of rights

ii. right to advice and assistance regarding any of the above rights

iii. right to have rights posted and distributed

The Committee's recommendation with respect to hospital records is made in light of the Supreme Court of Canada's decision in *McInerney v. MacDonald*.[121] In that case, the Supreme Court of Canada recognized a patient's right to have access to his or her own medical records, stating, "[I]n short, patients should have access to their medical records in all but a small number of circumstances. In the ordinary case, these records should be disclosed upon the request of the patient unless there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient or harm to a third party."[122]

With respect to the review process, the Committee recommends that the following be included in new legislation:

7. REVIEW BOARD

i. right to be informed of right to apply to review board for review of status
ii. right to have file reviewed by review board on request
iii. right to receive notice of hearing and information as to the process for the hearing
iv. right to appeal admission certificates, involuntary status, or incapacity
v. right to file application for review on decisions pertaining to status as patient
vi. right to be present at hearing, to present evidence, and to make submissions
vii. right to not have persons present at hearing other than the parties and members of review panel

8. RIGHT OF APPEAL

i. right to appeal decisions of review panel to Supreme Court, Family Division, or Family Court on issues of jurisdiction and errors of law
ii. right to not have court proceedings made public.

Question 18
A. Do you agree or disagree with the rights identified?
B. Are there other rights which you believe should be included?

B. Rights Advice

Provisions for patient rights advisors are found in various provinces' mental health legislation.[123] Some legislation provides for patient rights advisors and others refer to patient advocates. Regardless of terminology, the use of a patient rights advisor or patient advocate is generally seen as a means of assisting patients in psychiatric facilities to understand their rights, and to assist the patient in exercising his or her rights. Patient rights advisory services can also include providing assistance to a patient in the application for a review to the Review Board and in preparation for the hearing. Having a patient advisor service is a means of advancing the human rights and civil rights of involuntary patients.

The Committee recommends that all designated psychiatric facilities have access to a rights advisor to provide rights advice to patients, both involuntary and voluntary, and to those persons placed on community treatment orders. The rights advisor provides independent and confidential rights advice so that the patient/person is able to make informed decisions about his/her care, treatment and legal rights.

The Committee recommends that the mandate for patient rights advisors be as follows:

Mandate:

- *to advance the legal and civil rights of involuntary, voluntary or incapacitated patients in all designated psychiatric facilities in the province and any person in the community on a community treatment order.*
- *to inform the involuntary/voluntary patient, hospital staff, person on a community treatment order, community treatment providers and if appropriate, family about the patient/person's legal and civil rights*
- *to assist, facilitate and help resolve complaints made by voluntary or involuntary patients and persons on a community treatment order by providing an avenue for resolution.*

The Committee was in agreement that advice is required at the time a patient/person's status is determined to be involuntary; when a patient/person is deemed to be incapable of consenting to

treatment; when a patient/person is deemed to be incompetent to examine or consent to disclose his/her clinical record; when a person is placed on a community treatment order; or on request. While emphasis for rights advice is for the patient/person who is involuntary or found to be incapable, the mandate of the rights advice service would include providing service to voluntarily admitted patients. It is recommended that provisions detailing when advice is required be included in mental health legislation.

Question 19
A. Should a rights advisor be made available for both voluntary and involuntary patients or only for involuntary patients?
B. Should a rights advisor be made available for all patients or only for patients that do not have capacity?

The Committee also recognized that a patient/person should not be forced to accept the assistance of a rights advisor, and recommends the inclusion of the following provision:

> A patient is not required to meet with the rights advisor or receive the advice provided and may choose to refuse such advice.

1. Qualifications of Rights Advisor

The Committee is of the opinion that in order for a person to act as a patient rights advisor, there is an expectation that the person has met some basic requirements in order to fulfill the role effectively. It is the recommendation of the Committee that the following criteria be met in order for a person to qualify as a rights advisor. The Committee suggests including the criteria in regulations or policy.

i. *knowledge of relevant legislation, including the new Mental Health Act, the Medical Consent Act, and the Legal Aid Act*
ii. *knowledge of the purpose and mandate of the "Review Board"*
iii. *knowledge of how to obtain legal advice*
iv. *good communication skills*
v. *training for Boards and Tribunals provided by Department of Justice.*

Question 20
Do you agree with the qualifications that are outlined?

2. Roles/Responsibilities

It will be the duty of the Rights Advisor to offer assistance to persons who are detained in a designated psychiatric facility under certificates of observation, to patients under involuntary status or under a community treatment order and to patients/persons who have been found not capable of consenting to treatment. It is recommended that the roles and responsibilities of rights advisors be set as follows:

i. *meets promptly with all involuntary or incapacitated patients/persons*
ii. *explains the significance of the situation to the patient/person*
iii. *identifies available options*
iv. *communicates information in a neutral, non-judgemental manner*
v. *assists patient/person in making application to Review Board*
vi. *assists in obtaining legal counsel if requested and applying for legal aid*
vii. *accompanies patient/person to Review Board hearing*
viii. *assists in identifying alternate decision maker when patient/person lacks capacity/is incompetent*
ix. *maintains strict patient confidentiality*
x. *ensures that treatment providers are knowledgeable of/have access to patient rights information.*

Question 21
A. Do you agree with the role/responsibilities set out?
B. Are there other responsibilities that you believe should be added? Why?

3. Employment

The Committee is of the opinion that for a rights advisor system to be effective, the rights advisor must be independent. In order to ensure independence, it is felt that the rights advisor should not be employed by the psychiatric facility or by the Department of Health. As such, the Committee recommends that the legislation specify that the rights advisor shall be independent of both the Department of Health and the psychiatric facility.

Question 22
Do you agree with the proposal that the rights advisor be independent from the psychiatric facility and the Department of Health?

The Committee considered how such independence could be achieved. A mechanism for achieving independence is the use of a contract with an independent person or organization within the community that is familiar with relevant provincial legislation and the *Charter*. Another mechanism is having patient rights advisors appointed by the Governor in Council.[124] The Committee offers the following suggestions for inclusion in regulations or policy.

- The patient rights service be provided on a contractual basis between the Department of Health and individual(s) or group(s) in the community;
- Such contract(s) to be reviewed on a yearly basis;
- Restricting the contract to those who are not in the employ of the formal health care system (Department of Health, District Health Authorities/IWK).

4. Allocation of Rights Advisors

The Committee recognizes that not all psychiatric facilities will require the services of a full-time rights advisor. It is recommended that the allocation and distribution of patient rights advisors throughout the province should be based upon the demand for such advice.

5. Initiating the Rights Advisor Process

In order for a rights advisor to be able to assist a patient, the patient needs to know of the existence of the rights advisor and be able to engage the services of the rights advisor. There are two approaches that can be taken regarding the initiation of the rights advisor process. One approach is to advise the patient that a rights advisor is available, with the onus on the patient to initiate contact with the rights advisor. The second approach is to assign responsibility to the facility for initiating contact with the rights advisor.

The Committee recommends the first approach in those circumstances when the patient, either voluntary or involuntary, or subject to a community treatment order, is deemed capable. As such, access to the rights advisor would be on the basis of informed choice. The patient would be made aware of the rights advisor and would choose whether or not to use the service.

The Committee prefers the second approach for those patients that are deemed incapable of consenting to treatment or to examining or disclosing his or her clinical records. Under such circumstances, the onus is on the administrator to facilitate the rights advisor process. The purpose of having a rights advisor is to assist a person with understanding his or her rights. It may be assumed that if a person requires assistance in understanding his or her rights, it is also likely that the person will require assistance in accessing the rights advice system.

Therefore, the Committee recommends that the following provisions be included in the mental health legislation:

> *i. Where a person/patient is deemed to have capacity, the administrator shall inform the person/patient of the availability of a rights advisor. The decision to access the service of a rights advisor will be that of the person/patient.*

ii. The administrator of a psychiatric facility shall notify the rights advisor of the issuance of a certificate of observation, the issuance of a community treatment order, or the admission where such pertains to an incapable person.

Question 23
A. Do you agree with the recommendation of requiring the administrator to notify the rights advisor where the person/patient is deemed incapable?
B. Do you agree with the recommendation that when a person/patient is capable, the administrator will not notify the rights advisor but will inform the person/patient of the availability of the service?

PART VI: REVIEW BOARD

The Psychiatric Facilities Review Board is appointed under the mental health provisions of the Hospitals Act.[125] As noted in the Annual Report, the primary responsibilities of the Review Board are to review the decision of the treating psychiatrist that a person in a psychiatric facility should be held under 'involuntary'[126] status and that a person is not capable of consenting to treatment.[127] As also noted, the power of the Review Board to interfere with individual autonomy is unprecedented. The responsibilities and powers of the Review Board are formidable, since they can operate to deprive the individual of the right to make decisions concerning oneself and authorize continued detention against one's wishes even in situations in which no criminal act has been committed.[128]

The Committee discussed the appointment of members, constitution of the Review Board, scope of review, responsibilities of the Review Board, procedural issues in relation to hearings before the Review Board, and conflicts of interest. The following sections outline the Committee's recommendations on those matters.

A. Appointment and Constitution of Review Board

Currently, the statute provides that it is the Governor in Council who appoints members to the board and makes determinations regarding the term of an appointment as well as the re-appointment of members for succeeding terms.[129] The Governor in Council can also designate members to act as Chair and Vice-Chair. The Committee recommends that these provisions be maintained, with the exception of the appointment of a Vice-Chair.

The current legislation neither sets out who can be a member of the Review Board, nor does it specify qualifications for appointment to the Review Board.[130] However, in practice, a panel of the Review Board consists of a lawyer, a psychiatrist, and a lay-person. Generally, the lawyer acts in the capacity of Chair. A person who is or has been a mental health consumer is generally appointed in the lay-person category. Under the current provisions, in order for the Review

Board to have a quorum, three members must sit and it is the Chair who determines which members will sit on a particular review.

Therefore, the Committee proposes that the composition of the Review Board be included in the legislation and recommends the following:

1. *To be appointed to the Review Board, an individual must be a psychiatrist, a lawyer or a lay-person;*
2. *The psychiatrist must hold a current license to practice;*
3. *The lawyer must hold a minimum of a LLB or JD;*
4. *The lay-person should have an interest in mental health and preferably be or have been a consumer of mental health services;*
5. *The Chair of the Review Board and of each panel will be a lawyer;*
6. *The membership of the panel must consist of members of all three categories (psychiatrist, lawyer and lay-person);*
7. *A quorum is three members.*

As noted above, the Committee also recommends that there be no appointment of a Vice-Chair. Instead, the legislation should contain a provision that will allow the Chair or Chair's designate to arrange for the members to sit at a hearing. Such a clause will allow for the continuation of the practice of the Chair's secretary contacting members to arrange a Review Hearing. The Committee also recommends that the board's name be changed from Psychiatric Facilities Review Board to "Review Board".

Question 24
Do you agree with the recommendation for appointment of members?
Do you agree with the recommendation on the composition of the Review Board?

B. Scope of Review

Under the current provisions, the Review Board's functions and authority include (i) determining whether a patient shall continue to be detained under involuntary admission, (ii) determining

whether the requirements for psychosurgery have been complied with, (iii) reviewing a declaration of capacity, (iv) reviewing a declaration of competency, (v) making recommendations respecting the care or treatment of a patient, and (vi) advising on the transfer of a patient to another facility.[131]

The Committee recommends that the Review Board maintain the authority for determining whether a patient shall continue to be detained under involuntary admission, reviewing declarations of capacity, and reviewing declarations of competency. Furthermore, the Review Board should maintain the ability to make recommendations respecting the care or treatment of a patient, and for advising on the transfer of a patient to another facility.

With respect to psychosurgery, the Committee noted that psychosurgery has not been carried out in this province for many years. While the current Act includes provisions for carrying out psychosurgery, it is the recommendation of the Committee that the new legislation not include provisions referring to psychosurgery. As such, the provision giving the Review Board authority for ensuring that the requirements for carrying out psychosurgery are not necessary. The Committee notes that omitting provisions governing psychosurgery will not prevent a patient who requires psychosurgery from accessing this treatment outside Nova Scotia. Access for psychosurgery, like all out-of-province medical treatment, can be assessed through the process stipulated for out-of-province medical treatment under the *Health Services and Insurance Act*.

Although the Review Board has the authority to make recommendations respecting the care or treatment of a patient, it does not have the ability to make decisions about the treatment and care of a patient. The Committee recommends continuing this provision.

As detailed earlier, the Committee has recommended the inclusion of provisions for substitute decision makers. The Committee therefore suggests the following limited role for review by the Review Board regarding substitute decision makers.

(1) *a health professional could ask for a review as to whether a capable informed consent by the substitute decision maker has been rendered.*

(2) *the patient could ask for a review to determine whether a capable informed consent by the substitute decision maker has been rendered.*

(3) *the patient could challenge his or her own status as "incapable".*

Where the Review Board finds that a substitute decision maker has not rendered a capable informed consent, the next suitable substitute decision maker on the hierarchy list would become the substitute decision maker. "Suitable" means that the person meets the criteria for becoming a substitute decision maker.

The limitation on the role of the Board was recommended to address the potential issue of the Review Board being asked to overturn decisions of the substitute decision makers where the substitute decision maker refuses to consent to treatment and the psychiatrist disagrees with that decision. The Committee believes that the philosophy behind substitute decision makers is that the person who stands as a substitute decision maker stands in the place of the patient who does not have capacity to consent to treatment. As the Supreme Court of Canada has declared, a patient who has capacity is able to make his or her own health care decision, even where the decision to refuse treatment may result in the patient's death. Therefore, a decision of a substitute decision maker who has capacity and provides an informed consent should be respected, regardless of whether the decision is a refusal or agreement to the proposed treatment.

In light of the limited role of the Review Board with respect to substitute decision makers, the Committee makes the following recommendation for review by the court. The Committee recommends that a review by Family Court or Supreme Court (Family Division) can be requested where the substitute decision maker's decision is appealed on the basis that the criteria were inappropriately applied. In the event that the substitute decision maker is found not to have applied the criteria appropriately, the next suitable substitute decision maker on the hierarchy list will stand as the substitute decision maker.

Question 25
A. Do you agree with the recommended functions and authority for the Review Board?
B. Do you agree with the limited scope of review in relation to substitute decision makers?

C. Responsibilities

The Hospitals Act currently requires the Review Board to file a written decision within 14 days of the review, setting out the conclusion of the Review Board and to maintain a record of each review.[132] The Committee recommends shortening the time period for the written decision to 7 days of the review. Additionally, the Committee recommends that the written decision must include reasons for the Review Board's decision. The Committee recommends that the legislation maintain the provision granting the Review Board members the same powers and privileges as commissioners appointed under the *Public Inquiries Act*.[133]

D. Hearing

1. Review on Request

Under the current provisions of the *Hospitals Act*, a review hearing can take place upon the request of the patient, a person who is authorized by the patient to act on his behalf, the administrator of a facility where the person is a patient, the medical director of the facility where the person is a patient, the administrator of psychiatric mental health services, or the Minister.[134] The Committee's recommendation as to whom can request a review is not substantially different from the current provision. It is recommended that the following persons should be entitled to request a review: the patient, a guardian appointed by law, a proxy appointed under the *Medical Consent Act*, a person authorized by the patient to act on his or her behalf, the responsible administrator for the District Health Authority/IWK, and the Review Board where it believes it is in the patient's interest to have a review.

Under the current provisions, a hearing must be held within one month of the request.[135] The Committee recommends a shorter period of time in which the review must be held. It is

recommended that a Review Board hearing must be held as soon as possible but no longer than 14 calendar days following receipt of the request for a hearing.

Question 26
A. Do you agree with the recommendation as to whom may make a request for a hearing?
B. Do you agree with the recommended time period in which a hearing must take place?

2. Period Between Reviews on Request

Under the current provisions, the Review Board may refuse to conduct a review that is requested by the patient where there has been a review within the previous six months. The Committee recommends shortening the time period to 3 months. The following section is recommended:

> A Review Board may refuse to review the file of a patient upon the request of the patient at any time during the 3 months following the date the file was previously reviewed.

Question 27
Do you agree with the recommended 3-month time limit?

3.Mandatory Hearing by the Review Board

The *Hospitals Act* sets out when mandatory reviews of a patient's file must be carried out. Currently, a review must be conducted at least once every six months for the first two years that a patient is an involuntary patient, and following the first two years, at least once every twelve months.[136]

The Committee recommends the following changes: The first mandatory hearing will be 60 days following the beginning of the original involuntary declaration, then after 4 months (6 months hospitalization), and after 6 months (12 months hospitalization), and 6 months (18 months hospitalization), and 6 months (24 months hospitalization). If involuntary status is still

required after 24 months, a mandatory hearing will be required every 12 months thereafter. A mandatory review may not be required where a review was initiated and completed in that period.

Table 2: Proposed Mandatory Review Time

Time of Review from initial Involuntary Admission	60 days	4months	6 months	6 months	6 months	Every 12 Months Thereafter
Total Running Time	60 days	6 months	12 months	18 months	24 months	.....

Question 28
Do you agree with the proposed mandatory review times?

4. The Notice of Hearing

The *Hospitals Act* requires that where a mandatory hearing is to be held, notice must be given in writing to the patient, person authorized to act on behalf of the patient, the administrator of the facility, and to the person who requested the hearing. The Act also stipulates that notice must be given to the person at least three clear days before the date of the hearing, and that the notice must specify the time and place of the hearing. It is the recommendation of the Committee that the notification requirement be maintained at three "clear" days, with "clear" defined as meaning not to include weekends and statutory holidays.

5. Oral Hearings

The *Hospitals Act* stipulates that the patient, or the patient's representative shall have the right to attend and be heard at a review. The Committee recommends the Review Board be required to proceed by way of a full oral hearing when responding to a request for a hearing. Furthermore, it is to be understood that the mandatory hearings are full oral hearings.

The current provisions allow for the Review Board to require a patient to attend at his or her hearing. It is the recommendation of the Committee that this provision be removed from the new legislation. With respect to attendance at a hearing, the Committee makes the following recommendations:

> *A hearing shall be closed except for the patient, the patient advocate and/or support person, any person having material evidence, any person required for security reasons, and the treating psychiatrist.*

Furthermore, the Committee recommends that, in the event that the patient is not able or not willing to attend a hearing, the Review Board will have the right to appoint a representative for the patient.

Question 29
A. Do you agree with the recommendation that reviews be conducted as an oral hearing?
B. Do you agree with the recommendation that the patient or patient's substitute decision maker has the right to attend and be heard at the review hearing?
C. Do you agree with the Review Board having the authority to appoint a representative for a patient where the patient is unable or not willing to attend a hearing?

6. Onus of Proof

It is the recommendation of the Committee that the onus of proof during a Review Board hearing shall be explicitly borne by the facility.

E. Review of Community Treatment Orders

Currently, under the *Hospitals Act*, decisions related to formal admissions and capacity assessments are subject to review by the Review Board. In this manner, the Review Board acts as a safeguard for patients. The Committee is of the opinion that decisions related to community treatment orders should also be subject to review by the Review Board. In the provinces and territories that use community treatment orders or leave certificates, the decisions under those provisions are subject to review.

The Committee agreed that a person or someone on that person's behalf should be able to request a review, and that such a request can be made each time a community treatment order is issued or renewed. The Committee also considered the issue of mandatory reviews. The Committee makes the following recommendation:

1. Application for Review

> *A person who is subject to a Community Treatment Order, or any person on his or her behalf, may apply to the Review Board to inquire into whether or not the criteria for issuing or renewing a Community Treatment Order are met. Such an application may be made each time a Community Treatment Order is issued or renewed.*

2. Deemed Application

> *When a Community Treatment Order is renewed and on the occasion of every second renewal thereafter, the person shall be deemed to have applied to the Board, unless an application has already been made.*

3. Frequency of Review

> *Mandatory reviews are to occur at 6 months, and then every 12 months.*

Table 3: Proposed Mandatory Review Schedule for CTOs

6 months (from day 1 of CTO being issued.)	**18 months**	**30 months**	**42 months**	**54 months**

Question 30
A. Do you agree with the proposed review provisions?
B. Specifically, do you agree with the proposed mandatory review schedule?

F. Conflict of Interest

Under the current *Hospitals Act*, no member of a Review Board may sit on a panel that is considering the review of a patient of the member, a client of the member or a relative of the member.[137] The Committee believes that it is important to maintain the ability to exclude Review Board members from particular panels when they have specific affiliations with the patient. The Committee has recommended maintaining this approach. Furthermore, the Committee recommends that a "conflict of interest" should be declared by the member to the Review Board.

Under the current provisions, a member may sit on both the Review Board and the Criminal Code Review Board. The Committee is of the opinion that a member who has sat on a Criminal Code Review Board hearing for a patient, should not sit as a member on a panel of the provincial Review Board concerning the same patient, and recommends such a prohibition be included in the legislation.

The Committee also recommends that the legislation should also contain a general clause regarding the need to avoid conflicts of interest on the Review Board.

Question 32
A. Do you agree with the recommendation that members be excluded from sitting on a panel when there is a conflict of interest?
B. Do you agree with the inclusion of a prohibition of members sitting on both the Review Board and the Criminal Code Review Board for the same patient?

PART VII: MISCELLANEOUS

A. Personal Property

The *Hospitals Act* includes provisions relating to the administration of a person's estate.[138] The Committee is not making recommendations on these provisions, as a review of the administration of estate provisions were not within the scope of this review.

B. Confidentiality/Privacy

The *Hospitals Act* includes a provision on confidentiality of hospital records.[139] Amendments on the issue of confidentiality and privacy were not included in the scope of this review.

ENDNOTES

1. Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c.11.

2. The Law Reform Commission of Nova Scotia did a review of the *Hospitals Act* at the request of the Nova Scotia government. Its final report was released in February 2002. (*Mental Health Provisions of the Hospitals Act*. Law Reform Commission of Nova Scotia, February 2002).

3. A list of the Committee members is attached in the Appendix.

4.These provisions allow for psychiatric care and treatment (in-patient hospitalization as well as conditional community supervision and treatment) for accused individuals with a mental illness who are found by the courts to be not criminally responsible.

5. The Committee reached consensus on most but not all issues.

6. For example, the United Nations *Principles for the protection of persons with mental illness and the improvement of mental health care*, which was adopted by General Assembly resolution 46/119 of 17 December 1991. *Universal Declaration of Human Rights*, which was adopted and proclaimed by General Assembly Resolution 217A (III) of December 10, 1948; the *Declaration on the Rights of Mentally Retarded Persons*, which was proclaimed by the General Assembly Resolution 2856 (XXVI) of December 20, 1971; and the *Declaration on the Rights of Disabled Persons*, which was proclaimed by General Assembly resolution 3447 (XXX) of December 9, 1975.

7. (U.K.), 30 & 31 Vict., c.3, reprinted in R.S.C. 1985, App. II, No. 5.

8. *Charter*, *supra* note 1.

9. *Hospitals Act*, R.S.N.S.1989, c. 208. *[Hospitals Act]*

10. *Hospitals Act*, *ibid.*, section 34(1).

11. *Hospitals Act*, *ibid.*, section 35(1).

12. *Hospitals Act*, *ibid.*, section 39(3).

13. *Hospitals Act*, *ibid.*, sections 43(3)(5).

14. *Nova Scotia Standards for Mental Health Services in Nova Scotia*. Section D1. Department of Health, February 20, 2003.

15. J.E. Gray, M.A. Shone, P.F. Liddle, *Canadian Mental Health Law and Policy* (Toronto: Butterworths, 2000).

16. The mental condition is generally defined in terms such as "mental disorder" or "mental illness", with consequences identified as "danger to self", "danger to other" or "lack of ability to care for self". See, John Dawson, "Psychopathology and Civil Commitment Criteria" (1996) 4 Medical Law Review 62 at 62.

17. B. Hoggett. *Mental Health Law* (3rd ed.) in John Dawson, *ibid.* at 66.

18. *Hospitals Act*, *ibid.*, section 2(q).

19. Dawson, *supra*, note 17.

20. This approach is referred to as the psychopathological approach. See, Dawson, ibid.

21. *The Mental Health Services Act*, R.S.A. 2000, M-13. See also the definition of "mental disorder" in Manitoba's *Mental Health Act*, C.C.S.M. c. M 110. The definition is substantially the same: "Mental Disorder" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, but does not include a disorder due exclusively to a mental disability as defined in *The Vulnerable Persons Living with a Mental Disability Act*.

22. *Mental Health Act*, R.S.N.B. 1973, c. M-10. This approach is also seen in international legislation, see for example the definition of "mental illness" in the *Mental Health Act 1990* of New South Wales: "*Mental Illness*" means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterized by the presence in the person of any one or more of the following symptoms:
(a) delusions,
(b) hallucinations,
(c) serious disorder of thought form,
(d) a severe disturbance of mood,
(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).

23. Law Reform Commission, *supra* note 2 at 35.

24. *Uniform Mental Health Act*. Uniform law Conference of Canada. *Proceedings of the Sixty-Ninth Annual Meeting* (August, 1987), App. F at 262-310.

25. *Hospitals Act*, *ibid.*, section 36(2)(ii).

26. British Columbia, Saskatchewan, and Manitoba. Ontario also includes the deterioration criteria in limited circumstances.

27. The wording "requires inpatient services" does not mean mandatory treatment.

28. *Hospitals Act*, *ibid.*, section 34(4)(5).

29. *Hospitals Act*, *ibid.*, section 37.

30. *Hospitals Act*, *ibid.*, section 37.

31. *Hospitals Act*, *ibid.*, section 38.

32. *Hospitals Act*, *ibid.*, section 36(2).

33. *Hospitals Act*, *ibid.*, section 36(7).

34. *Hospitals Act*, *ibid.*, section 36(9).

35. The Law Reform Commission recommended that the courts retain the ability to direct a medical examination. See, *supra* note 2.

36. Family Court or Supreme Court Family Division

37. *Hospitals Act*, *ibid.*, section 34.

38. *Hospitals Act*, *ibid.*, section 42(1).

39. *Hospitals Act*, *ibid.*, section 42(2).

40. *Hospitals Act*, *ibid.*, section 44(1).

41. *Hospitals Act*, *ibid.*, section 39(2).

42. *Hospitals Act*, *ibid.*, section 42(1)(a)(b)

43. *Hospitals Act*, *ibid.*, section 44(2), (3).

44. Law Reform Commission, *supra* note 2 at 49.

45. *Supra* note 25.

46. See, *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119.

47. Erin Nelson. *The Fundamentals of Consent in Canadian Health Law and Policy* (2nd ed.) at 123.

48. *Ibid* at 120.

49. In *Starson* v. Swayse, [2003] S.C.J. No. 33 (S.C.C.) (QL). [*Starson*]

50. *Ibid*. Both the majority and minority decisions agreed with the underlying values. McLachlin C.J. also discusses the value of protecting society, but only in the context of mandatory hospitalization, not treatment.

51. *Starson*, *supra* note 50 at para. 7. Major J. also makes this point, at para. 76, quoting from the *Re Koch* decision, "The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake."

52. Starson, supra note 50 at para. 91.A majority of the SCC found that the decision of the Board was in error in that its finding that the patient did not have capacity was overly influenced by the Board's conviction that the medication was in the patient's best interest. It should be noted that the major point of departure between the majority and the minority in *Starson* was the patient's level of comprehension of his mental disorder. A minority of the court viewed Starson as being in denial of his disorder. The majority focussed on his awareness that his brain did not function normally, although he did not view this as an illness per se. According to the majority: "while a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to recognize that he is affected by that condition" (at para. 79).

53. Thomas Grisso & Paul S. Appelbaum, *Assessing Competence to Consent to Treatment*, (New York: Oxford University Press, 1998) at 18.

54. *Ibid* at 18.

55. Grisso, *supra* note 54 at 18.

56. *Starson, supra* note 50 at para. 75.

57. *Starson, supra* note 50 at para. 77.

58. *Starson, supra* note 50 at para. 77.

59. Grisso, *supra* note 54 at 20.

60. Grisso, *supra* note 54 at 21

61. Nelson, *supra* note 48 at 122.

62. Grisso, *supra* note 54 at 21.

63. Grisso, *supra* note 54 at 22.

64. Grisso, *supra* note 54 at 24.

65. Nelson, *supra* note 48 at 122.

66. Grisso, *supra* note 54 at 29.

67. Grisso, *supra* note 54 at 26.

68. Grisso, *supra* note 54 at 26.

69. *Hospitals Act*, *supra* note 10, section 52(2).

70. *Health Care Consent Act, 1996*, S.O. 1996, c.2, section 4(1).

71. *Hospitals Act, supra* note 10, section 54.

72. *Hospitals Act*, supra note 10, section 55.

73. *Hospitals Act*, supra note 10, section 56.

74. *Hospitals Act*, supra note 10, section 51.

75. *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181.

76. *Mental Health Act*, R.S.B.C. 1996, c. 288.

77. *Health Care (Consent) and Care Facility (Admission) Act*, *supra* note 76, section 2.

78. *Mental Health Act*, *supra* note 77, section 31.

79. *Mental Health Services Act*. C. M-13.1, section 24(1).

80. *Health Care Consent Act*, *supra* note 71, section 10.

81. *Ibid.*, section 10(2).

82. *Mental Health Act*, R.S.A., 2000, c. M-13, section 29. The factors that a review panel must consider in determining whether the proposed treatment is in the patient's best interest are: whether the mental condition of the patient will be or is likely to improve; whether the patient's condition will deteriorate or is likely to deteriorate without treatment; whether the anticipated benefit of the treatment outweighs the risk of harm to the patient; and whether the treatment is the less restrictive and least intrusive treatment that meets the other requirements.

83. (1991), 82 D.L.R. (4th) 298 (Ont.C.A.). The Supreme Court of Canada has cited the Fleming case with approval on several occasions.

84. Under the Nova Scotia *Medical Consent Act*, a person who is of the age of majority and capable of giving consent to medical treatment or directions respecting medical treatment, can authorize another person of the age of majority to give that consent in the future when the person making the directive is no longer capable of giving such consent. A person authorized under the *Medical Consent Act* to give consent to medical treatment is deemed to be a guardian for the purpose of giving medical consent pursuant to the *Hospitals Act*.

85. Latin term for "instead of a parent" or "in place of a parent".

86. Fleming. *Supra* note 84.

87. In Ontario, legislative changes allowing for CTOs passed Third Reading on June 21, 2000 with the support of 82 out of 103 members of the Ontario Legislature representing all three political parties. It was proclaimed on December 1, 2000. Ontario Ministry of Health and Long Term Care. Online: <http://www.health.gov.on.ca/english/public/pub/mental/treatment_order.html> (Accessed December 05, 2003).

88. Jurisdictions that contain leave provisions include, British Columbia, Alberta, Manitoba, Prince Edward Island, and New Brunswick. Saskatchewan's legislation includes leave provisions in addition to provisions for CTOs.

89. J. Dawson *et al.*, "Ambivalence about Community Treatment Orders" (2003) 26 International Journal of Law & Psychiatry 243; G.A. Fernandes & S. Nygard, "Impact of involuntary outpatient commitment on the revolving-door syndrome in North Carolina" (1990) 41 Hosp. Community Psychiatry 1001-4; P.S. Applebaum, "Thinking Carefully About Outpatient Commitment" (2001) 53(3) Psychiatric Services 347.

90. V.A. Hiday & R.R. Goodman, "The least restrictive alternative to involuntary hospitalization, outpatient commitment: its use and effectiveness" (1982) 10 J. Psychiatry Law 81; V.A. Hiday, "Outpatient Commitment: Official Coercion in the Community, in Coercion and Aggressive Community Treatment D. Dennis & J. Monahan (New York: Plenum, 1996); W. Obomanu & H.G. Kennedy, "'Juridogenic' harm: statutory principles for the new mental health tribunals", (2001) 25 Psychiatric Bulletin 231.

91. C.W. Lidz *et al.*, "Perceived Coercion in Mental Health Admission: Pressures and Process" (1995) 52(12) Arch. Gen. Psychiatry 1034.

92. This is the standard to be applied.

93. *Mental Health Act*, R.S.O., 1990, c. M.7. Section 33.5(2) allows for the appointment of a different physician where the original physician is unable to carry out his or her responsibilities.

94. *Mental Health Act*, *ibid.*,section 33.7.

95. *Mental Health Services Act*, *supra* note 80, section 24.3(1)(e).

96. *Mental Health Act*, *supra* note 22, section 46(9).

97. The Ontario legislation provides that a copy of the order must be given to the following persons:
(a) the person, along with a notice that he or she has a right to a hearing before the Board;
(b) the person's substitute decision-maker, where applicable;
(c) the officer in charge, where applicable; and
(d) any other health practitioner or other person named in the community treatment plan.

98. Under the Ontario *Mental Health Act* when a person is subject to a community treatment order, the person is required to (a) attend appointments with the physician who issued or renewed the community treatment order, or with any other health practitioner or other person referred to in the community treatment plan, at the times and places scheduled from time to time; and (b) comply with the community treatment plan described in the community treatment order.

99. *Hospitals Act*, *supra* note 10, section 65(1)(a) & (b). Subsections (c),(d),(e) and (f) allow for a review at the request of the administrator of a facility, the medical director of the facility, and administrator of psychiatric mental health services, and the Minister.

100. *Hospitals Act*, *supra* note 10, section 66(3).

101. *Hospitals Act*, *supra* note 10, section 66(5). The patient has the right to attend and be heard, unless it is otherwise ordered by a review board, in which case the patient's representative has the right to attend and be heard.

102. *Hospitals Act*, *supra* note 1, section 70.

103. *Hospitals Act*, *supra* note 10, section 70(8).

104. *Hospitals Act*, *supra* note 10, section 70(7).

105. See, British Columbia, *Mental Health Act*, *supra* note 77, section 34.1.

106. See, Northwest Territories. *Consolidation of Mental Health Act*, R.S.N.W.T. 1988, c. M-10, section 35; Alberta, *Mental Health Act*, *supra* note 83, section 14.

107. See, Northwest Territories, *Consolidation of Mental Health Act*, *ibid.*, section 35.

108. See, Manitoba, *Mental Health Act*, *supra* note 22, section 5.

109. See, British Columbia, *Mental Health Act*, *supra* note 77, section 34.1; Manitoba *Mental Health Act*, supra note 22, section 32.

110. See, British Columbia, *Mental Health Act*, 33; Manitoba *Mental Health Act*, section 32;Ontatio, *Mental Health Act*, section 38;

111. See, New Brunswick, *Mental Health Act*, R.S.N.B. 1973, c. M-10, section 31; British Columbia, *Mental Health Act*, *supra* note 77, section 25; Newfoundland, *Mental Health Act*, R.S.N. 1990, c. M-9, section 16.

112. British Columbia, *Mental Health Act*, *supra* note 77, section 31.

113. Ontario, *Health Care Consent Act*, *supra* note 71, section 10; Prince Edward Island, *Mental Health Act*, section 23.

114. Ontario, *Health Care Consent Act*, section 14

115. Prince Edward Island, *Consent to Treatment and Health Care Directives Act*, S.P.E.I. 1994, c. C-17.2, section 4

116. Prince Edward Island, *Consent to Treatment and Health Care Directives Act*, *ibid*, section 6; Ontario, *Health Care Consent Act*, *supra* note 71, section 11;

117. Prince Edward Island, *Consent to Treatment and Health Care Directives Act*, *ibid.*, section 6.

118. Northwest Territories, *Consolidation of Mental Health Act*, *supra* note 107, section 39.

119. Ontario, *Health Care Consent Act*, *supra* note 71, section 5.

120. Northwest Territories, *Consolidation of Mental Health Act*, *supra* note 107, section 40.

121. *McInerney v. MacDonald*, [1992] 2 S.C.R. 138.

122. *Supra* at page 140.

123. See, Ontario's *Mental Health Act & Regulation 741*; New Brunswick's *Mental Health Act & Regulation 94-33*; Alberta's *Mental Health Act* & *Regulation 310/89*.

124. In the province of Alberta, patient advocates are appointed by the Lieutenant Governor in Council. *Mental Health Act*, *supra* note 83, section 45(1).

125. *Hospitals Act*, *supra* note 10, section 61(1).

126. The terminology in the *Hospitals Act* is "formal" and "informal", the proposed wording is "voluntary" and "involuntary".

127. Psychiatric Facilities Review Board, Annual Report, April 1, 2001 - March 31, 2002. The Board also has authority to review competency to administer a patient's estate, where necessary, and to make recommendations as to the treatment, care or placement of a patient (section 63).

128. Psychiatric Facilities Review Board, Annual Report, April 1, 2001 - March 31, 2002.

129. See *Hospitals Act*, *supra* note 10, section 61(2).

130. However, some mental health legislation does specify the composition of the Review Board. For example, in British Columbia, the legislation specifies that the Review Board will consist of a Chair, a physician appointed by the treating facility, and a person who is appointed by the patient, which cannot be the patient or a member of the patient's family. See, *Mental Health Act*, *supra* note 77, section 25(5).

131. *Hospitals Act*, *supra* note 10, section 63.

132. *Hospitals Act*, *supra* note 10, section 67.

133. See, *Hospitals Act*, *supra* note 10, section 66(9).

134. *Hospitals Act*, *supra* note 10, section 65(1).

135. *Hospitals Act*, *supra* note 10, section 65(1).

136. *Hospitals Act*, *supra* note 10, section 64(a)(b).

137. *Hospitals Act*, *supra* note 10, section 62(3).

138. *Hospitals Act*, *supra* note 10, section 52(3).

139. *Hospitals Act*, *supra* note 10, section 71(1).

APPENDIX
Mental Health Legislation Development Committee
Membership

Mr. Dennis Holland, Co-Chair
Senior Director, Legislative Policy
NS Department of Health

Ms. Linda Smith, Co-Chair
Director, Child and Youth Health Services
Mental Health Services
NS Department of Health

Dr. John A. Campbell
Director, Adult Mental Health Services
NS Department of Health

Ms. Dianna Fortnum
Director, Mental Health Services
Colchester East Hants District Health Authority

Ms. Elaine Gibson
Previous Chair, Facilities Review Board
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Ms. Sara Gorelick
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Mr. Dean Hirtle
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Mr. Leroy Lenethen
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